CCAP 2
Rev. 02/06
01/06 Issue Obsolete

Louisiana Department of Social Services
Office of Family Support
Child Care Assistance Program

Application for Child Care Assistance

OFFICE USE ONLY
SSN _____
Worker _____
☐ New Application
☐ Redetermination
_____ Redet M/Y

1. IDENTIFYING INFORMATION: This form should be completed by the parent or other household member who is responsible for paying child care costs.

PLEASE PRINT ALL INFORMATION

NAME: LAST FIRST MIDDLE INITIAL

HOME ADDRESS: STREET APT. NO. CITY PARISH ZIP

MAILING ADDRESS: STREET/ P.O. BOX APT. NO. CITY PARISH ZIP

TELEPHONE #S: HOME: ( ) WORK: ( ) OTHER PHONE: ( )

2. **HOUSEHOLD COMPOSITION:** For this program, a household includes these individuals who live together: Head of Household, Head of household's legal or non-legal spouse, and all dependent children under age 18. List yourself first, then other household members with the oldest members listed first.

NAME (FIRST, MI, LAST)	RELATIONSHIP TO YOURSELF	BIRTH DATE	RACE	SEX	(OPTIONAL) SSN	MARITAL STATUS
	Self					

Is anyone listed above pregnant? ☐ Yes ☐ No If yes, list the person's name and due date.
Name: _____ Due Date: _____

Is any adult or parent listed above disabled? ☐ Yes ☐ No If yes, list the person's name and attach verification of disability (doctor's statement, etc) Name: _____

Are all children listed above U. S. citizens? ☐ Yes ☐ No If no, list their names: _____

3. **CHILDREN NEEDING CARE:** List the times each day that child care is needed for each child (if school-aged children need care both before and after school, list both times; example: 7:00 to 8:00 and 3:30 to 6:00). **NOTE:** If you have not yet selected a child care provider, enter the child's name, age, time each day care is needed, and check the type of care that you plan to use.

NAME OF CHILD	AGE	TYPE OF CARE ONE PER CHILD	NAME/ADDRESS/PHONE# OF PROVIDER	PROVIDER / CHILD RELATIONSHIP	TIME NEEDED EACH DAY	COST OF CARE
		☐ Child's Home ☐ Provider's Home ☐ Class A Center ☐ Other				
		☐ Child's Home ☐ Provider's Home ☐ Class A Center ☐ Other				
		☐ Child's Home ☐ Provider's Home ☐ Class A Center ☐ Other				
		☐ Child's Home ☐ Provider's Home ☐ Class A Center ☐ Other				

4. Are immunizations current on all children in need of child care? ☐ Yes ☐ No If no, list their names: _____

List children from Item 3 who attend/will attend Head Start, Pre-Kindergarten, or Kindergarten this year: _____

5. **PERSONS WHO ARE EMPLOYED:** Enter the name of each parent and person age 18 and over listed in # 2 (on the reverse side) who is working. List ALL jobs (working means full-time, part-time, temporary, self-employment, or odd-job employment, even if the job has just started or will end soon). **Send in check stubs for the 4 most recent pay periods (for each person who is employed).** If check stubs are not available, we will supply a form for the employer to complete to verify earnings for the 4 most recent pay periods.

Person Employed	Name And Address Of Employer	Employment Begin Date	Work Hours/Week	Work Days/Week	Gross Amount Earnings	How Often Paid

6. **OTHER TYPES OF INCOME:** Check the appropriate column next to the type of income that you or any member of your household receives or has applied for. **Send in proof of any income that is checked.**

Source Of Income	RECEIVES	Applied For	Person Who Applied/Receives	Amount Received	How Often
A. Child Support					
B. Alimony					
C. Unemployment Benefits					
D. SSI-Supplemental Security Income					
E. Social Security Benefits					
F. Veteran's Benefits					
G. Retirement Benefits					
H. Other Disability Benefits					
I. Adoption Subsidy					
J. Other Income Type (contributions, etc.)					

7. **PERSONS WHO ARE IN SCHOOL OR TRAINING:** Enter the name of each parent and person age 18 and over listed in #2 (on the reverse side) who is attending a job training or educational program. **Send in verification of school or job training attendance, including the number of hours in class each week and the anticipated date of completion.**

Person In Training	Name And Address Of School	Class Hours/Week	Class Days/Week	Anticipated Completion Date

8. **PERSONS WHO ARE LOOKING FOR EMPLOYMENT:** Enter the name of each parent and person age 18 and over listed in #2 who needs child care assistance to look for work: _____

9. **CASH ASSISTANCE FROM FITAP (Family Independence Temporary Assistance Program)**: Does any member of your household receive FITAP, or has anyone's FITAP case been closed within the past 2 months? ☐ Yes ☐ No If Yes, is/was this person receiving child care assistance? ☐ Yes ☐ No If either question above is answered yes, list the name(s) of the person(s) receiving assistance: _____

10. **SPECIAL NEEDS:** Does any child, under age 18, need specialized child care because of a physical, mental, or emotional condition**?** ☐ Yes ☐ No If Yes, who? _____ For what type of condition? _____

Is any child receiving SSI or other disability benefits? ☐ Yes ☐ No If Yes, send copy of award letter or copy of a recent check.

RIGHTS AND RESPONSIBILITIES:

The fact that you are applying for or receiving assistance from this agency means you have certain rights and responsibilities.

You have the right to confidentiality -- that means that the information given by you will not be released without your written consent, except to agencies and officials as allowed by law. We do not discriminate in the delivery of services. This means you will not be treated differently from others because of your race, color, sex, age, disability, religious beliefs, nation origin or political beliefs. If you think you have been discriminated against, you can file a complaint which will be investigated and appropriate action will be taken.

A decision will be made on your application **within 30 days** after the date the application is received. You will receive written notice of the decision. You can request a Fair Hearing to have the Department of Social Services review the decision of the OFS Parish office handling your case if you think it is not fair. You or your representative may request a Fair Hearing, orally or in writing, if you disagree with any action taken on your case. Your case may be presented at the hearing by any person you choose.

AGREEMENT: I agree to let the office know within 10 days if any of the following changes occur. I understand that I must report changes that occur after I send in my application, as well as changes that occur after I am determined eligible.

- Change in Address
- Change in Members of my Household, including anyone who moves in or out
- Change in employment, including an interruption for at least three weeks, or a change of employer, or a change in the number of hours worked
- Change in income if household's gross monthly income changes more than $100 in earned income or $50 in unearned income
- Change in job training or educational program, including an interruption for at least three weeks, a change of programs, or a change in the number of hours of attendance.
- Change in Child Care Providers, Provider's Type
- Change in location of where care is being provided
- Change in Days or Hours Child(ren) attends Child Care
- Absence from Child Care for 5 or more consecutive days
- Beginning or ending of disability
- Termination of job search

If I am in a Food Stamp Semi-Annual Reporting (SAR) household, I understand I am only responsible for reporting within ten days the following:

- Change in gross monthly income, which results in the household's income exceeding the gross income limit for food stamps.
- Change of Child Care providers.
- A child receiving child care benefits moves out of the home.
- Interruption of at least three weeks, or termination of employment, training, or education for any parent or adult household member.
- Termination of job search.

If a child is absent from Child Care for five (5) or more consecutive days, the child may no longer be eligible for Child Care Assistance benefits. If you have not reported an excusable reason for the absence, your child's eligibility will terminate after ten (10) consecutive days of absences.

Providing false information, withholding information, or failing to report any of the changes as described above is subject to penalty under the law. If providing false information or withholding information causes an overpayment for child care, you may be required to repay the amount of ineligible benefits that you received to the Office of Family Support. If you purposely fail to report any information that causes you to receive benefits for which you are not eligible for fraud charges may be brought against you and you may be disqualified from participating in the program.

Social Security Numbers are not required for Child Care Assistance eligibility and eligibility cannot be denied for failure to provide Social Security Numbers.

I give permission to the Agency to contact whomever necessary to verify my need for assistance. In addition, I hereby waive the confidentiality of my name and Social Security Number, if provided, so that information may be furnished to employers, government agencies, and any other parties deemed necessary in order to verify my income and need for assistance, or for data collection or statistical purposes.

With my signature below, I certify that I have read and understand my rights and responsibilities. I hereby declare that the times care is needed as listed in item 3 are the times when I and any other Training or Employment Mandatory Participant are working and/or attending a job training or educational program or traveling to and from these activities. I certify under penalty for perjury that all information given on this application form is true and correct to the best of my knowledge.

Signature of Applicant _____ Date _____

Signature of Legal or non-legal Spouse _____ Date _____

OFFICE USE ONLY
CLARIFICATIONS: